

Financial Assistance

Getting Help to Pay Your Bill

This information is for anyone who receives services from an AdventHealth facility or an affiliated health care provider. You can view a list of AdventHealth facilities at www.adventhealth.com. As a faith-based hospital system, we provide medical care to all patients, including those who have difficulty paying for services due to limited income. You can ask for help with your bill at any time during your hospital stay or billing process.

Qualifying for Help

If you receive emergency or medically necessary services and do not have medical coverage from a commercial insurer or governmental program, you may qualify for financial assistance. The amount of assistance depends on your annual income and family size. If your annual income is equal to or less than 200% of the current Federal Poverty Guidelines you will not have to pay your bill.

2021 Federal Poverty Guidelines	
Household Size	200% of Poverty
1	\$25,760
2	\$34,840
For each additional person in the household, add \$4,540	

If your income does not meet the guidelines to have your entire bill paid, you may still qualify for help paying part of your bill. You may also qualify based on other factors on your application.

Applying for Help

You can apply for help with your bill in person, by mail or over the phone. To receive an application, call our Customer Service department, visit our website or go to the patient registration area at our hospital. Our phone number, website and address are located on the financial assistance section of our website and on the first page of this document when printed. This information is also available in other languages on our website or at the patient registration area.

Emergency and Medically-Necessary Care

If you qualify for help with your bill, you will not be billed more for emergency or medically-necessary care than people who have insurance coverage are billed. We compare the amount paid by insured patients and their insurance companies to determine how much you owe. You can view our charity policy on our website.

Supporting Documents

If you want to take part in our financial assistance program, you will be responsible for providing information and paperwork in a timely way. You will need to share all the information about your health benefits, income, assets, and anything else that will help us determine whether you qualify for assistance. Paperwork might include bank statements, income tax forms and check stubs.

Collection Activities

Bills that are not paid 100 days after the first billing date may be reported to a collection agency. Bills that are not paid 120 days after the first billing date may be reported on your or your guarantor's credit history. You or the guarantor can apply for help with your bill at any time during the collection process by completing an application.

Financial Assistance Application

(All fields must be completed unless noted otherwise)

Patient Last Name, First	Date of Birth	Social Security Number	*Number of people in Household	Last 12 Months Annual Household Income \$
If Minor, Guarantor's Last Name, First	Date of Birth	Social Security Number	Guarantor's Source of Income	
Vehicles in Household including Cars/Boats/RV's (Year/Make/Model) (Optional)	Checking/Savings Account Balance (Optional)	Properties Owned and Values (Optional)	CD/Retirement/Investment Account Balances (Optional)	Other Assets (Optional)
Patient Street Address		Home Phone Number	If income is \$0, please check one:	
City, State, Zip Code		Alternate Phone Number		
Number of children under age 21 in the home: _____			<input type="checkbox"/>	Lives with Relative(s)
			<input type="checkbox"/>	Lives with Friend(s)
			<input type="checkbox"/>	Retired
			<input type="checkbox"/>	Unemployed
			<input type="checkbox"/>	Disabled
<input type="checkbox"/>	Homeless			

Please read before signing. I CERTIFY that the information I have provided is true and accurate to the best of my knowledge. I will independently or with the assistance of hospital personnel apply for ANY and ALL ASSISTANCE which may be available through federal, state, local government and private sources to help pay this hospital bill. I understand that if I do not cooperate with my hospital provider in providing requested information, my application may be denied for possible financial assistance. I hereby grant permission and authorize any accredited agent of the Medicaid program to disclose to my hospital provider ALL information regarding the status of my Medicaid application and if the application is not approved and the reason for disapproval. I will ASSIGN to my hospital provider ALL FUNDS received from the above sources, which are provided to help with this HOSPITAL BILL. I, on my own behalf, and for my immediate family member(s), authorized representative(s), physician(s), counselor(s) (including clergy), and attorney(s), agree to hold and maintain in strictest confidence any written communication and/or oral discussions between me and my hospital provider regarding matters relating to services provided to me by my hospital provider. I understand that the information which I submit is subject to verification by my hospital provider, including credit reporting agencies, and subject to review by FEDERAL and/or STATE AGENCIES and others as required. I AUTHORIZE my employer to release to my hospital provider my proof of income. I UNDERSTAND that if any information I have given proves to be untrue, my hospital provider will re-evaluate my financial status and take whatever action becomes appropriate. **To qualify for assistance, at least one piece of supporting documentation that verifies household income may be required. Supporting documentation can include but is not limited to, most recent year's tax return, a current W-2, notarized letter of support, etc. Requests for assistance may be denied if supporting documentation is not provided. Any unpaid balance will be eligible for further collection action.** *[State of Florida Applicants: Florida Statute s.817.50 (1). Whoever shall, willfully and with intent to defraud, obtain or attempt to obtain goods, products, merchandise or services from any hospital in this state shall be guilty of a misdemeanor of the second degree, punishable as provided in s.775.082 or s.775-083.]*

Signature of Applicant /Guarantor

Date Completed

* When calculating the number of people in the household, only the following people are counted: 1) Blood relatives living in the home, 2) Relatives by marriage living in the home, and 3) Relatives by legal adoption living in the home.

For Office Use Only

For Office Use Only				
Reason for Service	GAI	DOS	Family Size	Total Charges
1.0x	1.5x	2.0x	25% Rule	
\$	\$	\$	\$	
Recommendation for account disposition				
Finance Committee Disposition				
_____	_____	_____	_____	_____
Manager	Date	Director	Date	

Purpose

AdventHealth (AH) is committed to excellence in providing high quality health care while serving the diverse needs of those living within our service area. AH is dedicated to the view that emergency or other non- elective medically necessary care should be accessible to all, regardless of age, gender, geographic location, cultural background, physical mobility, or ability to pay. AH is committed to providing health care services and acknowledges that in some cases an individual will not be financially able to pay for the services received. This policy is intended to comply with Section 501(r) of the Internal Revenue Code and the regulations promulgated thereunder and shall be interpreted and applied in accordance with such regulations. This policy has been adopted by the governing body of each AH hospital facility in accordance with the regulations under Section 501(r).

AH provides emergency or other non-elective medically necessary care to individual patients without discrimination regardless of their ability to pay, ability to qualify for financial assistance, or the availability of third- party coverage. In the event that third-party coverage is not available, an allocation is made each year for funds to be available for financial assistance. Wherever possible, a determination of eligibility for financial assistance will be initiated prior to, or at the time of admission, by the financial counselor. This policy identifies those circumstances when an AH hospital organization or a substantially-related entity (a partnership providing emergency or other medically necessary care in which the AH hospital organization has an ownership interest) should provide care without charge based on the financial need of the individual.

The financial assistance policy provides guidelines for financial assistance to eligible self-pay individual patients and eligible individual patients with balances after insurance receiving emergency or other non-elective medically necessary services based on financial need.

This financial assistance policy also provides guidelines for amounts that may be charged to all self-pay patients who receive medically necessary services. Financial assistance discounts based upon financial need will not be provided for elective procedures, except as may be determined in the sole discretion of the AH hospital facility on a case-by-case basis.

Non-elective services are defined as a medical condition that without immediate attention:

- Places the health of the individual in serious jeopardy
- Causes serious impairment to bodily functions or serious dysfunction to a bodily organ.

Patients types assumed to be covered by this definition include, but are not limited to:

- Emergency Department Outpatients
- Emergency Department Admissions
- IP/OP follow-up related to previous Emergency visit.

Policy

Please see the Addendum to this Policy for a listing of all providers, other than the AH hospital facility, that deliver emergency or other medically necessary care at the AH hospital facility, and specifies which providers are covered by this Financial Assistance Policy and which are not. The listing of providers contained in the Addendum to the Policy can be accessed on-line at the AH hospital facility's website. A paper copy can be obtained free of charge from the AH hospital facility's Patient Financial Services Department.

The provider listing is updated quarterly to add new or missing information, correct erroneous information, and delete obsolete information. The date of the most recent update is included on the provider listing.

An AH hospital facility may list names of individual doctors, practice groups, or any other entities that provide emergency or medically necessary care in the AH hospital facility by the name used either to contract with the hospital or to bill patients for care provided.

- A. Emergency or non-elective medically necessary care may be considered for financial assistance if a patient presents with any of the following conditions:
1. No third-party coverage is available.
 2. Patient is already eligible for assistance (e.g. Medicaid), but the particular services are not covered.
 3. Medicare or Medicaid benefits have been exhausted and the patient has no further ability to pay.
 4. Patient is insured but qualifies for assistance based upon financial need with respect to the individual's balance after insurance.
 5. Patient meets local and/or state charity requirements.
 6. Patients may apply for financial assistance in accordance with the guidelines set forth in this Policy.
- B. Financial Assistance Policies, Financial Assistance Application Forms, and Plain Language Summaries of the Financial Assistance Policies are transparent and available to the individuals served at any point in the care continuum in languages that are appropriate for the AH service area in compliance with the Language Assistance Services Act and in the primary languages of any populations with limited proficiency in English that constitute the lesser of 1,000 individuals or 5% of the members of the community served by the AH hospital facility (limited proficiency in English populations meeting the criteria above will be referred to hereafter in this policy as the LEP defined populations).

Policy

1. Website: AH hospital facilities will prominently and conspicuously post complete and current versions of the following on their respective websites:
 - a. Financial Assistance Policy (FAP)
 - b. Financial Assistance Application Form (FAA Form)
 - c. Plain Language Summary of the Financial Assistance Policy (PLS)
 - d. Contact information for AH facility Financial Counselors.
2. The website will indicate that a copy of the FAP, FAA Form, and PLS is available and how to obtain such copies in the primary languages of the LEP defined populations.
3. Signage will be conspicuously displayed in public locations in AH hospital facilities including all points of admission and registration areas, including the Emergency Department. All signage denoting that financial assistance may be available will contain the following elements:
 - e. The hospital facility's website address where the FAP, PLS, and the FAA Form can be accessed
 - f. The telephone number and physical location (room number) that individuals can call or visit to obtain copies of the FAP, FAA Form or PLS or to obtain more information about the FAP, PLS, or the application process.
4. Contact information for how and where individuals that are members of the LEP defined populations may obtain copies of the FAP, FAA Form, and PLS. Each AH hospital facility will make paper copies of the FAP, FAA Form and the PLS available upon request and without charge, both in public locations in the hospital facility (including the Emergency Department and all admission and registration areas) and by mail. Paper copies will be available in English and in the primary languages of any LEP defined populations. A paper copy of the PLS will be offered to patients as part of the intake or discharge process.
5. Financial Counselor Visits: Financial counselors will seek to provide personal financial counseling to all individuals admitted to an AH hospital who are classified as self-pay. Interpreters will be used, as indicated, to allow for meaningful communication with individuals who have limited English proficiency. Financial assistance eligibility criteria and discount information will be made available.
6. The PLS should be distributed to members of the community served by the AH hospital facility in a manner reasonably calculated to reach those members of the community who are most likely to require financial assistance. An example would be the distribution of copies of the PLS to organizations in the community that address the health needs of low-income populations.
 - c. AH and the individuals served each hold accountability for the general processes related to the provision of financial assistance.

Policy

1. AH Responsibilities:

- a. AH has a financial assistance policy to evaluate and determine an individual's eligibility for financial assistance.
- b. AH has a means of widely publicizing and communicating the availability of financial assistance to all individuals in a manner that promotes full participation by the individual.
- c. AH workforce members in Patient Financial Services and Registration areas understand the AH financial assistance policy and are able to direct questions regarding the policy to the proper hospital representatives.
- d. AH requires all contracts with third party agents who collect bills on behalf of AH to include legally binding written contract provisions that provide that these agents will follow AH financial assistance policies.
- e. The AH Revenue Cycle Department provides organizational oversight for the provision of financial assistance and the policies/processes that govern the financial assistance and billing and collection processes.
- f. After receiving the individual's request for financial assistance, AH notifies the individual of the eligibility determination within a reasonable period of time.
- g. AH provides options for payment arrangements.
- h. AH upholds and honors individuals' right to appeal decisions and seek reconsideration.
- i. AH maintains (and requires billing contractors to maintain) documentation that supports the offer, application for, and provision of financial assistance for a minimum period of seven years.
- j. AH will periodically review and incorporate federal poverty guidelines for updates published by the United States Department of Health and Human Services.

2. Individual Patient Responsibilities

- a. To be considered for a 100% reduction in charges under the financial assistance policy, the individual must cooperate with AH to provide the information and documentation necessary to apply for other existing financial resources that may be available to pay for healthcare, such as Medicare, Medicaid, third-party liability, etc.
- b. To be considered for a 100% reduction in charges under the financial assistance policy, the individual must provide AH with financial and other information needed to determine eligibility (this includes completing the required application forms and cooperating fully with the information gathering and assessment process).

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- c. A self-pay patient who is not eligible for a 100% reduction in charges based upon financial need will be billed no more than the amount generally billed to individuals who have insurance covering such care and will cooperate with the hospital to establish a reasonable payment plan.
 - d. A self-pay patient who does not qualify for a 100% reduction in charges based upon financial need must make good faith efforts to honor the payment plans for their hospital bills. The individual is responsible to promptly notify AH of any change in financial situation so that the impact of this change may be evaluated against financial assistance policies governing the provision of financial assistance, their hospital bills or provisions of payment plans.
 - d. Financial assistance eligibility determinations and the process of applying for financial assistance will be equitable, consistent, and timely.
1. Identification of Potentially Eligible Individuals. Requests for financial assistance will be honored up to 240 days after the date the first post-discharge billing statement is remitted to the individual either by mail or electronic bill presentment.
- a. Registration and pre-registration processes promote identification of individuals in need of financial assistance.
 - b. Financial counselors will make best efforts to contact all self-pay inpatients during the course of their stay or at time of discharge.
 - c. The AH hospital facility's PLS will be offered along with the FAA Form to every individual upon intake or upon discharge from the hospital facility.
 - d. A conspicuous written notice will be included on all billing statements that notifies and informs recipients about the availability of financial assistance under the AH hospital facility's FAP and includes the following: 1) the telephone number of the AH hospital facility's office or department that can provide information about the FAP and the financial assistance application process; and 2) the web- site address where copies of the FAP, FAA Form, and PLS may be obtained.
 - e. Reasonable attempts will be made to orally notify individuals about the AH hospital facility's FAP and how the individual may obtain assistance with the FAA Form and process.
 - f. The individual will be provided with at least one written notice (notice of actions that may be taken), along with a copy of the PLS, that notifies and informs the individual that financial assistance is available for eligible individuals and states that the hospital may take action to report adverse information about the individual to consumer credit reporting agencies/credit bureaus or engage in other specified extraordinary collection actions if the individual does not submit a FAA Form or pay the amount due by a specified deadline. This deadline cannot be earlier than 120 days after the first post-discharge billing statement is sent to the individual. The notice must be provided to the individual at least 30 days before the deadline specified in the notice.

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2. Requests for Financial Assistance. Requests for financial assistance may be received from multiple sources (including the patient, a family member, a community organization, a church, a collection agency, caregiver, Administration, etc.).
 - a. Requests received from third parties will be directed to a financial counselor.
 - b. The financial counselor will work with the third party to provide resources available to assist the individual in the application process.
 - c. Upon request, an estimated charges letter will be provided to individuals who request a written description of estimated charges.
3. Eligibility Criteria
 - a. To be eligible for a 100% reduction from applicable charges (i.e., full write-off for self-pay patients and full write-off of the patient responsibility portion of charges after insurance) the individual's household income must be at or below 200% of the current Federal Poverty Guidelines. Self-pay patients with household incomes that exceed 200% of the current Federal Poverty Guidelines will be charged no more than the amount generally billed to individuals who have insurance covering such care.
 - b. The amount charged to any FAP-eligible individual for emergency or all other medically necessary care will be based on amounts generally billed (AGB) to individuals who have insurance covering such care at each specific AH hospital. Each AH hospital facility will determine its AGB by determining an AGB percentage and multiplying that percentage by the gross charges for the services provided to the individual. All AH hospital facilities will utilize the look-back method as described in §1.501(r)-5(b)(3) to determine AGB. Individuals can contact a member of the relevant AH hospital's Patient Financial Services team at a telephone number shown on an attachment to this policy to obtain a free written information sheet stating the relevant AH hospital facility's AGB percentage and an explanation of how the AGB percentage was determined.
 - c. Charges to an individual eligible for financial assistance under the AH hospital facility's FAP for any medical services will be less than the gross charges for that care.
 - d. If the 200% maximum financial assistance threshold needs to be expanded for market-specific conditions (including competition and public relations), the entity's representative is to present the exception to the AdventHealth Senior Hospital Finance Group (SHFG) Committee for approval.
 - e. In addition to an income level evaluation as outlined above, an optional asset means test may also be applied to determine eligibility for financial assistance. An asset test is mandatory for Medicare patients only. An asset test for non-Medicare patients is optional. For the purposes of this policy, the amount of patient responsibility is 100% of the patient portion not to exceed the GREATER of: 1) Seven percent (7%) of Available Assets or 2) Required payment per the Financial Assistance Policy. "Available Assets" is defined as cash, cash equivalents and non-retirement investments.

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f. When determining an individual’s income, the following terms apply:

i. Household size and income includes all members of the immediate family and other dependents in the household as follows:

1. An adult and, if married, a spouse.
2. Any natural or adopted minor children of the adult or spouse.
3. Any minor for whom the adult or spouse has been given the legal responsibility by a court.
4. Any student over 18 years old, dependent on the family for over 50% support (current tax return of the responsible adult is required).
5. Any other persons dependent on the family’s income for over 50% support (current tax return of the responsible adult is required).

g. Income can be verified by using a personal financial statement or by obtaining copies of that applicant’s most recent Form W-2, most recent Form 1040, bank statements or any other form of documentation that supports reported income.

h. Documentation supporting income verification and Available Assets is to be maintained in patient files for future reference.

i. A credit report may be generated for the purpose of identifying additional expense, obligations and income to assist in developing a full understanding of the individual’s financial circumstances. A third-party scoring tool may be used to justify financial assistance eligibility.

j. Financial assistance application forms will be considered up to 240 days after the first post-discharge billing statement is remitted to the patient or when a change in patient financial status is determined. A financial assistance application will not need to be repeated for dates of service incurred up to three (3) months after the last date of application approval.

k. Presumptive eligibility: Individuals who are uninsured and are represented by one or more of the following may be considered eligible for the most generous financial assistance in the absence of a completed Financial Assistance Application Form:

- Individual is homeless;
- Individual is deceased and has no known estate able to pay hospital debts;
- Individual is incarcerated for a felony;
- Individual is currently eligible for Medicaid, but was not at the date of service;
- Individual is eligible by the State to receive assistance under the Violent Crimes Victims Compensation Act or the Sexual Assault Victims Compensation Act;

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- Individual has a payment risk score of “D” or “E” based on the Scorer® application. The Scorer application is a tool that is designed to classify individuals into groups of varying economic means. The scores consist of algorithms that incorporate data from credit bureaus, demographic databases, and hospital specific data to infer and classify individuals into respective economic means categories. In lieu of utilizing the Scorer application, credit bureau scores may also be used to determine presumptive eligibility at the hospital’s discretion.
- Individual was determined to be eligible for financial assistance any time within the previous three- month period beginning after the date the last financial assistance application was approved.

For any individual presumed to be eligible for financial assistance in accordance with this policy, the same actions described in this Section D and throughout this policy would apply as if the individual had submitted a completed Financial Assistance Application Form.

4. Method for Applying for Financial Assistance

- a. AH Financial Assistance Application Form. In order to apply for financial assistance, the individual will complete the AH Financial Assistance Application Form. The individual will provide all supporting data required to verify eligibility, including supporting documentation verifying income. See Financial Assistance Implementation Instructions for CWF 50.1 for acceptable forms of documentation.
- b. An individual can obtain a copy of the AH Financial Assistance Application Form by accessing it on the AH hospitals’ website, by requesting a free copy by mail, by contacting the AH hospitals’ Patient Financial Services department, or by requesting a copy in person at any of the AH hospitals’ patient admission/ registration locations.
- c. A completed AH Financial Assistance Application Form will be submitted to Patient Financial Services for processing. Proof of income and available assets will be required from the individual. In addition, Medicare beneficiaries are subject to an additional asset test in accordance with federal law. A review is completed to determine individual eligibility based on the individual’s total resources (including but not limited to family income level, assets (as required for Medicare patients) and other pertinent information).

5. Actions that May be Taken in the Event of Non-Payment: After a 120- day period beginning with the date that the first post-discharge billing statement is sent to an individual, an AH facility may report outstanding debts for care provided to an individual to consumer credit reporting agencies or credit bureaus or make a sale of debt that is considered an extraordinary collection action (ECA) (please see Section F. 6. of the Policy), or engage in any other specified ECA’s only after the following notifications have been provided to the individual at least 30 days before initiating any ECA’s: 1) a written notice, along with the PLS, is provided to the individual indicating that financial assistance is available for eligible individuals and stating the specific ECA’s that may be initiated after a stipulated deadline

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(the deadline may not be earlier than 30 days after the written notice is provided), and 2) a reasonable attempt is made to orally notify an individual about the AH hospital facility's FAP and how the individual may obtain assistance with the financial assistance application process.

- a. No Financial Assistance Application Form Submitted: If no Financial Assistance Application Form has been submitted in the 120-day period following the date after the first post-discharge billing statement was sent to the individual and the stipulated deadline in the written notice has passed, the AH facility may initiate an ECA.
- b. Incomplete Financial Assistance Application Form Submitted: If an individual submits an incomplete Financial Assistance Application Form during the 240-day period following the date on which the first post-discharge billing statement was sent to the individual (the application period), the AH hospital must take the following actions:
 - i. Suspend any ECA's.
 - ii. Provide the individual with a written notice that describes the additional information and/or documentation required under the Financial Assistance Policy or Financial Assistance Application Form that the individual must submit within a reasonable time and that contains contact information including the telephone number and physical location of the AH hospital facility office or department that can provide information about the FAP, as well as contact information of a hospital facility office or department that can provide assistance with the financial assistance application process or, alternatively, a nonprofit organization or governmental agency that can provide assistance with the financial assistance application process if the AH hospital facility is unable to do so;
 - iii. If the Financial Assistance Application Form is not completed by the reasonable time deadline discussed above, the hospital may initiate or resume ECA's. Liens attached to insurance (auto, liability, life and health) that represent potential proceeds owed as a result of an individual's personal injuries for which the AH hospital facility provided care are permitted in connection with the collection process. No other personal judgments or liens will be filed against FAP-eligible individuals.
- c. Complete Financial Assistance Application Submitted: If an individual submits a complete Financial Assistance Application Form during the application period (240 days after the first post-discharge billing statement is sent), the AH hospital must take the following actions:
 - i. Suspend any ECA's.
 - ii. Suspend any collection activity during the consideration of a completed AH Financial Assistance Application Form. A note will be entered into the patient's account to suspend collection activity until the financial assistance process is complete. If the account has been placed with a collection agency, the agency will be notified to suspend collection efforts until a determination is made. This notification will be documented in the account notes.

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- iii. Make and document the determination as to an individual’s eligibility for financial assistance.
- iv. Notify the individual in writing in a timely manner, generally within 60 days, after receiving a completed Financial Assistance Application Form of the eligibility determination and the basis for the determination.
- v. Provide the individual with a billing statement (not required for a \$0 balance billing statement) that indicates the amount owed as a FAP-eligible individual and describes how the individual can get information regarding the AGB for care and how the AH hospital facility determined the amount the individual owes.
- vi. Refund any excess payments to the individual.
- vii. Take all reasonably available measures to reverse any ECA’s that have been taken against the individual.
- viii. Provide a written notification of denial to any individual determined to not be FAP-eligible and include both a reason for denial and a process and contact information for filing an appeal. If an individual disagrees with the decision to deny the provision of financial assistance, the individual may request an appeal in writing within 45 days of the denial. The appeal must include any additional relevant information that may assist in the appeal evaluation. Requests for denial appeal will be reviewed on a monthly basis by the Financial Assistance Committee. Decisions reached by the Financial Assistance Committee will be communicated to the individual within 60 days of the Committee’s review and will reflect the Committee’s final decision.
- ix. Upon receipt of a complete FAA Form, the AH hospital facility may postpone its determination of an individual’s eligibility under its FAP if the individual has submitted an application for Medicaid assistance until such time as Medicaid eligibility has been determined.

E. Patient Financial Services Responsibilities

1. Financial Assistance Committee: A summary of the financial assistance applications and resulting recommendations processed by Patient Financial Services will be reviewed monthly by the hospital’s Financial Assistance Committee. The Financial Assistance Committee reviews all financial assistance recommendations, with a focused review on borderline or non- routine requests that require case-by-case review.
2. Provision of financial assistance that exceeds \$10,000 must be approved by the Financial Assistance Committee.
3. Following review and approval by the Financial Assistance Committee, the approved financial assistance will be applied to the individual’s account by Patient Financial Services.

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4. Patient Financial Services has the responsibility for determining that the hospital has made reasonable efforts to determine whether an individual is FAP-eligible and whether the hospital may take action to engage in any ECA's.
5. Billing agencies that contract with AH for collection services will follow this financial assistance policy with respect to all billing and collections matters.
6. Selling an individual's debt to another party (other than a non- ECA sale as described below) is considered an ECA and should not be initiated until the required steps outlined above in Section D. have been completed. Any proposed sale of debt agreement must be approved by the relevant AH Regional CFO and submitted to the AH Contract Review Process before being executed. Certain sales of debt are not considered ECA's. Non-ECA debt sales require that the AH hospital facility enter into a legally binding written agreement with the purchaser of the debt that stipulates the following:
 - a. The purchaser may not engage in any ECA's.
 - b. The purchaser is prohibited from charging interest on the debt in excess of an IRS established rate.
 - c. The debt is returnable or recallable by the AH hospital facility upon a determination that the individual is FAP- eligible; and
 - d. If the debt is not recalled or returned, the purchaser must ensure that the individual does not pay more than he or she is personally responsible for as a FAP-eligible individual.
 - f. Individual Payment Plans
 1. Payment plans for self-pay patients who are charged AGB will be individually developed with the individual patient. All collection activities will be conducted in conformance with the federal and state laws governing debt collection practices. No interest will accrue to account balances while payments are being made unless the individual has voluntarily chosen to participate in a long-term payment arrangement that bears interest applied by a third-party financing agent.
 2. If an individual complies with the terms of his or her individually developed payment plan, no collection action will be taken.
 - g. Record-Keeping
 1. A record, paper or electronic, will be maintained reflecting authorization of financial assistance along with copies of all application and worksheet forms.
 2. Summary information regarding applications processed and financial assistance provided will be maintained for a period of seven years. Summary information includes the number of patients who applied for financial assistance at AH, how many patients received financial assistance, the amount of financial assistance provided to each patient, and the total bill for each patient.

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3. The cost of financial assistance will be reported annually in the Community Benefit Report. Financial Assistance (Charity Care) will be reported as the cost of care provided (not charges) using the most recently available operating costs and the associated cost to charge ratio.

H. Subordinate to Law: The provision of financial assistance may now or in the future be subject to federal, state or local law. Such law governs to the extent it imposes more stringent requirements than this policy.

Donald L. Jernigan, President/CEO

November 13, 2015 (Effective January 1, 2016 Origination Date: March 2006

Revision Date: February 26, 2008

December 18, 2008

November 13, 2014

Reviewed and Affirmed: N

Submit financial assistance documents using the AdventHealth contact information below
AdventHealth Financial Assistance Web Page Address:
www.adventhealth.com/legal/financial-assistance

SERVICE LOCATION	MAILING INFORMATION	PHONE / FAX
Altamonte Springs	Patient Financial Services PO BOX 538815 Orlando, FL 32853-9902	Phone: 407-303-0500 Fax: 407-200-4977
Apopka	Patient Financial Services PO BOX 538815 Orlando, FL 32853-9902	Phone: 407-303-0500 Fax: 407-200-4977
Celebration	Patient Financial Services PO BOX 538815 Orlando, FL 32853-9902	Phone: 407-303-0500 Fax: 407-200-4977
East Orlando	Patient Financial Services PO BOX 538815 Orlando, FL 32853-9902	Phone: 407-303-0500 Fax: 407-200-4977
Kissimmee	Patient Financial Services PO BOX 538815 Orlando, FL 32853-9902	Phone: 407-303-0500 Fax: 407-200-4977
Orlando	Patient Financial Services PO BOX 538815 Orlando, FL 32853-9902	Phone: 407-303-0500 Fax: 407-200-4977
Winter Garden	Patient Financial Services PO BOX 538815 Orlando, FL 32853-9902	Phone: 407-303-0500 Fax: 407-200-4977
Winter Park	Patient Financial Services PO BOX 538815 Orlando, FL 32853-9902	Phone: 407-303-0500 Fax: 407-200-4977
For Children	Patient Financial Services PO BOX 538815 Orlando, FL 32853-9902	Phone: 407-303-0500 Fax: 407-200-4977
For Women	Patient Financial Services PO BOX 538815 Orlando, FL 32853-9902	Phone: 407-303-0500 Fax: 407-200-4977
Heart of Florida	Patient Financial Services PO BOX 865836 Orlando, FL 32886-5836	Phone: 866-481-2553 Fax: 941-341-3717
Lake Wales	Patient Financial Services PO BOX 865836 Orlando, FL 32886-5836	Phone: 866-481-2553 Fax: 941-341-3717

Daytona Beach	Patient Financial Services 770 West Granada Blvd Ste 203 Ormond Beach, FL 32174	Phone: 888-676-2219 Fax: 386-676-2560
DeLand	Patient Financial Services 770 West Granada Blvd Ste 203 Ormond Beach, FL 32174	Phone: 888-676-2219 Fax: 386-676-2560
Fish Memorial	Patient Financial Services 770 West Granada Blvd Ste 203 Ormond Beach, FL 32174	Phone: 888-676-2219 Fax: 386-676-2560
New Smyrna Beach	Patient Financial Services 770 West Granada Blvd Ste 203 Ormond Beach, FL 32174	Phone: 888-676-2219 Fax: 386-676-2560
Palm Coast	Patient Financial Services 770 West Granada Blvd Ste 203 Ormond Beach, FL 32174	Phone: 888-676-2219 Fax: 386-676-2560
Waterman	Patient Financial Services 1000 Waterman Way Tavares, FL 32778	Phone: 352-253-3311 Fax: 352-253-3735
Carrollwood	Patient Financial Services PO Box 861372 Orlando, FL 32886-1372	Phone: 813-615-7848 Fax: 813-615-8182
Dade City	Patient Financial Services PO Box 865667 Orlando, FL 32886-5667	Phone: 813-615-7848 Fax: 813-615-8182
Lake Placid	Patient Financial Services PO Box 9400 Sebring, FL 33871 Attn: MB 3	Phone: 863-386-7177 Fax: 863-402-3389
Connerton	Patient Financial Services PO Box 861372 Orlando, FL 32886-1372	Phone: 813-615-7848 Fax: 813-615-8182
North Pinellas	Patient Financial Services PO Box 862624 Orlando, FL 32886-2624	Phone: 813-615-7848 Fax: 813-615-8182
Ocala	Patient Financial Services PO Box 865696 Orlando, FL 32886-5696	Phone: 813-615-7848 Fax: 813-615-8182
Sebring	Patient Financial Services PO Box 9400 Sebring, FL 33871 Attn: MB 3	Phone: 863-386-7177 Fax: 863-402-3389

Tampa	Patient Financial Services 12470 Telecom Dr., Ste. 200 Tampa, FL 33637	Phone: 813-615-7848 Fax: 813-615-8182
Wauchula	Patient Financial Services PO Box 9400 Sebring, FL 33871 Attn: MB 3	Phone: 863-386-7177 Fax: 863-402-3389
Wesley Chapel	Patient Financial Services PO Box 864855 Orlando, FL 32886-4855	Phone: 813-615-7848 Fax: 813-615-8182
Zephyrhills	Patient Financial Services PO Box 862310 Orlando, FL 32886-2310	Phone: 813-615-7848 Fax: 813-615-8182
Durand	Patient Financial Services 7315 E. Frontage Road, Suite 200 Shawnee Mission, KS 66204	Phone: 913-676-7558 Fax: 913-676-7571
Ottawa	Patient Financial Services 7315 E. Frontage Road, Suite 200 Shawnee Mission, KS 66204	Phone: 913-676-7558 Fax: 913-676-7571
Shawnee Mission	Patient Financial Services 7315 E. Frontage Road, Suite 200 Shawnee Mission, KS 66204	Phone: 913-676-7558 Fax: 913-676-7571
South Overland Park	Patient Financial Services 7315 E. Frontage Road, Suite 200 Shawnee Mission, KS 66204	Phone: 913-676-7558 Fax: 913-676-7571
Manchester	Patient Financial Services 54 Brownsberger Circle Fletcher, NC 28732	Phone: 800-347-5281 Fax: 828-650-8080
Murray	Patient Financial Services 54 Brownsberger Circle Fletcher, NC 28732	Phone: 800-347-5281 Fax: 828-650-8080
Gordon	Patient Financial Services 54 Brownsberger Circle Fletcher, NC 28732	Phone: 800-347-5281 Fax: 828-650-8080
Hendersonville	Patient Financial Services 54 Brownsberger Circle Fletcher, NC 28732	Phone: 800-347-5281 Fax: 828-650-8080
Central Texas	Patient Financial Services 2201 S. Clear Creek Road Killeen, TX 76549	Phone: 254-519-8476 Fax: 254-519-8488
Rollins Brook	Patient Financial Services 608 N. Key Avenue Lampasas, TX 76550	Phone: 254-519-8476 Fax: 254-519-8488